pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **THE VILLAGES OF HILLTOP HEIGHTS, LLC**
LEGAL ENTITY

To operate **THE VILLAGES OF HILLTOP HEIGHTS**
NAME OF FACILITY OR AGENCY

Located at **100 WOODMONT ROAD, JOHNSTON, PA 15905**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Assisted Living**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **106**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2800: Assisted Living Residences
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **January 22,** **2024** until **July 22,** **2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **338661**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: JANUARY 22, 2024

[redacted], Administrator
The Villages of Hilltop Heights, LLC
[redacted]

RE: The Villages of Hilltop Heights
100 Woodmont Road
Johnstown, Pennsylvania
15905 License #: 338661

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on September 19-20, 2023 and November 14, 2023 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), the Department hereby REVOKES your certificate of compliance (338660) dated July 1, 2023 to July 1, 2024 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026(b)(1) and 55 Pa. Code §20.71(a)(2);(4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal

must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *THE VILLAGES OF HILLTOP HEIGHTS* **License #**: *33866* **License Expiration**: *07/01/2024*

Address: *100 WOODMONT ROAD, JOHNSTON, PA 15905*

County: *CAMBRIA* **Region**: *CENTRAL*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *THE VILLAGES OF HILLTOP HEIGHTS, LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-1*	**Date**: *06/28/1995*	**Issued By**: *Department of Health*
Type: *C-1*	**Date**: *11/08/1989*	**Issued By**: *Department of Health*
Type: *C-2 LP*	**Date**: *11/01/1987*	**Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *81* **Waking Staff**: *61*

Inspection Information

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Complaint, Incident, Interim* **Exit Conference Date**: *07/20/2023*

Inspection Dates and Department Representative

07/19/2023 - On-Site: [redacted]

07/20/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106* **Residents Served**: *75*

Special Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *73*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *6* **Have Physical Disability**: *3*

Inspections / Reviews

07/19/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/14/2023*

08/15/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/01/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/22/2023*

08/25/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/01/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/01/2023*

01/09/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *09/01/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

42b Abuse/Neglect

1. Requirements

2800.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 6/24/23 at 7:45 PM, a physical altercation occurred between Resident 2 and 7 when they were fighting over a cane. Resident 7 was sent to the hospital to be evaluated for head, neck, back, and should pain after falling down. Resident 2 received a skin tear and a bruised cheek during the incident.

Plan of Correction ***Directed (- 08/24/2023)***

At the time of the incident resident 7 was moved to a different room on a different floor. Residents will be provided education on Home Rules. Education to be completed by 8/25/2023. Education will be provided to staff on how to identify signs of abuse and how to report suspected abuse. Education to be completed by 9/12/2023. POC education will be in addition to annual abuse/neglect trainings. Administrator or designee will touch base with both residents weekly x 6 weeks to ensure residents remain abuse free.

(Directed)
Beginning 8/28/23, The administrator will meet with Residents 2 and 7 independently at least once per week to identify potentially aggressive behaviors and offer support, including psychiatric intervention if necessary. The administrator will document these meetings and any interventions that are implemented. The documentation will be available for review by the Department upon request.

Beginning 8/28/23, the administrator will interview a sample of staff weekly who work on different days and shifts (at least 6 staff persons) to identify any problematic resident interactions and ensure these behaviors are identified, reported and addressed appropriately. Documentation of these interviews will be kept and available for review by the Dept. upon request. Any issues identified will be the subject of staff training and discussed during the quarterly quality management meeting.

Directed Completion Date: *09/12/2023*

Not Implemented (- 12/04/2023)

54a Direct care staff quals

2. Requirements

2800.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff A and B, do not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept - 08/24/2023)***

Administrator and/or designee will ensure that all new employees upon hire have a high school diploma, GED and/or our active on the Pennsylvania nurse aide registry. At time of plan of correction staff member A has not worked any hours on the floor and high school diploma has been obtained and is on file in facility and staff member B no longer works at the facility. Administrator or designee will be implementing a checklist for all new hires prior

54a Direct care staff quals (continued)

to their first day of work. This checklist will include copies of a valid ID, social security card, high school diploma/GED/or active CNA, as well as any valid certifications. The checklist must be complete by the first day of employment and will be kept in the employees file.

Licensee's Proposed Overall Completion Date: *08/22/2023*

Not Implemented [redacted] - 12/04/2023)

63a First Aid/CPR 1:35

3. Requirements

2800.
63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

Description of Violation

The home has a resident census of 75, requiring at least three staff to be present with current training in first aid and certified in obstructed airway techniques and CPR.

On 7/2/23 from 6:00 PM to 11:00 PM, two staff were present with current training and certification. From 11:00 PM to 6:00 AM on 7/3, one staff was present with current training and certification.

On 7/3/23 from 4:30 PM to 11:00 PM, two staff were present with current training and certification. From 11:00 PM to 8:00 AM on 7/4, no staff was present with current training and certification.

On 7/4/23 from 8:00 AM to 3:00 PM, one staff was present with current training and certification. From 6:30 PM to 3:00 AM on 7/5, one staff was present with current training and certification.

On 7/5/23 from 3:00 AM to 8:00 AM, no staff was present with current training and certification.

On 7/9/23 from 7:00 AM to 11:00 AM, no staff was present with current training and certification. From 11:00 AM to 11:00 PM, one staff was present with current training and certification. From 11:00 PM to 7:00 AM on 7/10, no staff was present with current training and certification.

On 7/12/23 from 4:30 PM to 11:00 PM, one staff was present with current training and certification. From 11:30 PM to 3:30 AM on 7/13, no staff was present with current training and certification.

Plan of Correction ***Directed [redacted] - 08/24/2023)***

Administration and/or designee will set-up a class and will have everyone recertified in CPR and 1st aide. All staff with CPR/1st aide expiring in 2023 will have recertification completed no later than 8/29/2023. CPR class to be held on 8/29/23. CPR cards will be kept in employee files. A tracking component to be created by administration to monitor CPR expiration dates. Administrator or designee to ensure that correct staff coverage is being provided.

(Directed)
Administration and/or designee will set-up a class and will have everyone recertified in CPR and 1st aide. All staff with CPR/1st aide expiring in 2023 will have recertification completed no later than 8/29/2023. CPR class to be held on 8/29/23. CPR cards will be kept in employee files. Beginning on 9/1/23, a tracking component to be created by administration to monitor CPR expiration dates. Administrator or designee to ensure that correct staff coverage is

63a First Aid/CPR 1:35 (continued)

being provided.

Directed Completion Date: *09/01/2023*

Not Implemented [redacted] - 12/04/2023)

65a Fire Safety-1st day

4. Requirements

2800.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Staff person A, whose first day of work was [redacted]/23, did not receive orientation on the following: Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable; Smoking safety procedures, the home's smoking policy and location of smoking areas; Telephone use and notification of emergency services.

Staff person B, whose first day of work was [redacted]/23, did not receive orientation on the following: Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable; Smoking safety procedures, the home's smoking policy and location of smoking areas; Telephone use and notification of emergency services.

Staff person C, whose first day of work was [redacted]23, did not receive orientation on the following: Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable; Smoking safety procedures, the home's smoking policy and location of smoking areas; Telephone use and notification of emergency services.

Plan of Correction ***Directed ([redacted] - 08/24/2023)***

Administrator and/or designee will utilize the facility's new hire orientation checklist coupled with RELIAS learning to ensure new hire trainings required by PA 2800 are completed prior to direct care being provided. Staff members requiring fire safety training will have retraining completed no later than 9/8/2023. The facility Administrator or designee will conduct whole house education on the requirements of 65a. This training will take place prior to 9/8/2023. In order to maintain compliance employee files will be audited monthly x 3 months to ensure trainings are completed.

(Directed)
Administrator and/or designee will utilize the facility's new hire orientation checklist coupled with RELIAS learning to ensure new hire trainings required by PA 2800 are completed prior to direct care being provided, this process will be utilized for all new hires, beginning 9/15/23. Staff members requiring fire safety training will have retraining completed no later than 9/8/2023. The facility Administrator or designee will conduct whole house education on the requirements of 65a. This training will take place prior to 9/8/2023. Beginning 9/18/23, all employee files will be audited monthly x 3 months to ensure trainings are completed.

Directed Completion Date: *09/18/2023*

Not Implemented ([redacted] - 12/04/2023)

65e Rights/Abuse 40 Hours

5. Requirements

2800.
65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff B and C, who have completed their 40th scheduled work hours, did not complete training in the following topics:
- Emergency Medical Plan
- Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102)
- Reporting of reportable incidents and conditions.
- Safe management techniques.
- Core competency training that includes the following:
i. Person-centered care.
ii. Communication, problem solving and relationship skills.
iii. Nutritional support according to resident preference.

Plan of Correction ***Directed [redacted] - 08/24/2023)***

Administrator and/or designee will ensure that all new employees will be given an orientation using the new Staff Orientation Plan prior to doing hands-on care which will include training on the following topics: emergency medical plan, mandatory reporting of abuse and neglect under the Older Protective Services Act, Reporting of reportable incidents and conditions, safe management techniques and core competency training that includes the following: person-centered care; communication, problem solving and relationship skills; and nutritional support according to resident preference. Staff member B no longer works in the facility. Staff member C will complete this education on 8/22/23. Administrator or designee to audit employee files to ensure all requirements of 2800.65 are met in regard to new hire orientation.

(Directed)
Administrator and/or designee will ensure that all new employees will be given an orientation using the new Staff Orientation Plan prior to doing hands-on care which will include training on the following topics: emergency medical plan, mandatory reporting of abuse and neglect under the Older Protective Services Act, Reporting of reportable incidents and conditions, safe management techniques and core competency training that includes the following: person-centered care; communication, problem solving and relationship skills; and nutritional support according to resident preference. Staff member B no longer works in the facility. Staff member C will complete this education on 8/22/23. Beginning 9/1/23, the Administrator or designee will audit all new hire employee files to ensure all requirements of 2800.65 are met in regard to new hire orientation. If any employees are identified as missing orientation trainings, they will not be permitted to work until those trainings are completed and documented in their file.

Directed Completion Date: *09/01/2023*

Not Implemented [redacted] - 12/04/2023)

82c Locked poisons

7. Requirements

2800.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the residence are able to safely use or avoid poisonous materials.

82c Locked poisons *(continued)*

Description of Violation

On 7/19/23 at 11:30 AM, an unlocked and unattended housekeeping cart with a bottle of Windex and FaciliPro Disinfectant Cleaner was accessible to residents on the first floor. On 7/20/23 at 4:30 PM, an unlocked storage room contained a 19 Oz can of Lysol Pro. These products all had manufacturers' labels indicating "to call a poison control center right away if ingested." Not all of the residents, including Resident 8, have been assessed capable of recognizing and using poisons safely.

Repeated Violation - 5/5/23, et al.

Plan of Correction ***Directed ([redacted] - 08/24/2023)***

Administrator and/or designee will provide an education to all staff, including housekeeping, on the importance of keeping poisonous materials locked and out of sight of all residents. Education will begin 8/25/2023 and be completed by 9/8/2023. Administrator or designee will ensure that housekeeping carts remain stored in a locked area when not in use. Administrator or designee will audit the floors daily x 7 days and then weekly x 3 weeks to ensure that poisons remain locked.

(Directed)
Administrator and/or designee will provide an education to all staff, including housekeeping, on the importance of keeping poisonous materials locked and out of sight of all residents. Education will begin 8/25/2023 and be completed by 9/8/2023. Administrator or designee will ensure that housekeeping carts remain stored in a locked area when not in use. Beginning 9/11/23, the Administrator or designee will audit the floors daily x 7 days and then weekly x 3 weeks to ensure that poisons remain locked, any poisons that are identified during these audits as unlocked will immediately be secured by the Administrator or designee.

Directed Completion Date: *09/11/2023*

Implemented ([redacted] - 12/04/2023)

88a Floors, walls, ceilings, windows, doors

8. Requirements

2800.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

There are several stained ceiling tiles throughout the home. One ceiling tile in the first floor hallway across from the medication room is damp and stained with flecks of dirt or mold.

Plan of Correction ***Accept ([redacted] - 08/24/2023)***

Education will be provided to Maintenace on keeping surfaces in good repairs and free of hazards. Ceiling tiles will be replaced by Maintenace. Moving forward any surface that is not in good repair will be reported to Maintenace using the facility's notification system to have repairs made in real time. Tiles will be replaced no later than 9/1/2023. Maintenace to order tiles to be replaced. Maintenance is notified of issues that need to be fixed by a binder that is located at each nurse's station on floors 1 and 2. Maintenance checks binders multiple times through the day.

Licensee's Proposed Overall Completion Date: *09/01/2023*

Not Implemented ([redacted] 12/04/2023)

141a Medical evaluation

9. Requirements

2800.
141.a.2 A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following: (11)

Description of Violation

The medical evaluations for the following residents do not include an indication that a tuberculin skin test has been administered with negative results within 2 years, as this area is blank:

- Resident 1's medical evaluation dated [redacted]/23
- Resident 2's medical evaluation dated [redacted]/23
- Resident 3's medical evaluation dated [redacted]/23

Plan of Correction ***Accept [redacted] - 08/24/2023)***

Administrator and/or designee will ensure that all residents TBs are up-to-date and included on their medical evaluations. A whole house audit of all ADME will be completed to ensure TB documentation is completed. Resident 1, 2, and 3's medical evaluations to be updated no later than 9/1/23. Whole house audit of resident ADME will take place between 9/5/23 and 9/8/23. ADME to be updated as necessary based on audit findings.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Not Implemented ([redacted] - 12/04/2023)

141b1 Annual medical evaluation

10. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident 4's most recent medical evaluation was completed on [redacted]/21.

Plan of Correction ***Directed [redacted] 08/24/2023)***

Administrator and/or designee will perform a whole house audit beginning on 8/11/23 and be completed by 8/31/23. A medical evaluation will be completed for anyone who does not have one. A record will be kept of when annual medical evaluations are due and will be attained annually as they are due. Administrator or designee will create a tracking system to maintain compliance that includes all resident annual ADME dates.

(Directed)
Administrator and/or designee will perform a whole house audit beginning on 8/11/23 and be completed by 8/31/23. A medical evaluation will be completed for anyone who does not have one. A record will be kept of when annual medical evaluations are due and will be attained annually as they are due. Beginning 9/1/23, the Administrator or designee will create, and utilize a tracking system to maintain compliance that includes all resident annual ADME dates, any annual ADME's coming due within 30 days will be scheduled by the Administrator or designee.

Directed Completion Date: *09/01/2023*

Implemented [redacted] - 12/04/2023)

183a Original containers / no pre-pour / injections

11. Requirements

2800.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

Medication packets are prepared for residents who leave the residence to attend off-site activities or programming. The medications are removed from their original packages and placed into plastic envelopes, stapled, and the names of the medications are written in marker on the envelopes by staff. This includes Resident 3's Gabapentin and Hydralazine which were packaged in this manner on 7/7/23 and Resident 7's Buspirone and Carbidopa-Levodopa which were packaged in this manner on 7/12/23.

Plan of Correction ***Directed ([redacted] - 08/24/2023)***

Administrator and/or designee will provide education to the med-techs beginning on 8/10/2023 to be completed by 8/28/2023 on the proper way to package medications when being sent on LOA. Medications will be sent in their original packaging per regulation guidelines. The Administrator or designee will ensure that medications are sent in their original packaging and will monitor weekly x 3 weeks how medications are sent when a resident goes on an LOA.

(Directed)
Administrator and/or designee will provide education to the med-techs beginning on 8/10/2023 to be completed by 8/28/2023 on the proper way to package medications when being sent on LOA. Medications will be sent in their original packaging per regulation guidelines. Beginning on 9/4/23, the Administrator or designee will ensure that medications are sent in their original packaging and will monitor weekly x 3 weeks how medications are sent when a resident goes on an LOA.

Directed Completion Date: *09/04/2023*

Implemented [redacted] 12/04/2023)

184a Resident meds labeled

12. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy label for Resident 5's Lantus Solostar insulin states to administer 12 units at bedtime. The prescriber's order for this medication states to inject 14 units at bedtime.

Plan of Correction ***Directed ([redacted] - 08/24/2023)***

Administrator and/or designee will provide education to staff on how to read medication labels and that if label is incorrect to notify LPN charge nurse so that they can put a change of direction sticker on it. Education will begin 8/25/23 to be completed by 9/8/2023. Upon notification of violation the Administrator/designee placed a change of direction sticker on the insulin pen to refer to the MAR for the change in dosage. Administrator or designee will audit all insulin pens in the facility weekly x 4 weeks and monthly x 3 months to ensure all changes in orders are

184a Resident meds labeled (continued)

captured and appropriately documented.

(Directed)
Administrator and/or designee will provide education to staff on how to read medication labels and that if label is incorrect to notify LPN charge nurse so that they can put a change of direction sticker on it. Education will begin 8/25/23 to be completed by 9/8/2023. Upon notification of violation the Administrator/designee placed a change of direction sticker on the insulin pen to refer to the MAR for the change in dosage. Beginning 9/4/23, the Administrator or designee will audit all insulin pens in the facility weekly x 4 weeks and monthly x 3 months to ensure all changes in orders are captured and appropriately documented.

Directed Completion Date: *09/04/2023*

Implemented (- 12/04/2023)

185a Storage procedures

13. Requirements

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

The glucometers for the following residents were not programed with the correct time when observed on 7/19/23:

- Resident 4's meter showed a time of 1:42 PM but the actual time was 3:32 PM
- Resident 5's meter showed a time of 1:13 PM but the actual time was 3:10 PM
- Resident 6's meter showed a time of 1:01 PM but the actual time was 2:54 PM

Plan of Correction ***Directed - 08/24/2023)***

: Administrator and/or designee will provide education to staff on how to set glucometer's and how to check them for correct date and time. Education will begin on 8/25/2023. Education to be completed by 9/8/2023. A whole house audit will be completed to ensure glucometers are calibrated and set to the appropriate date/time. The day of inspection all glucometers were correctly calibrated to the day and time by the Administrator/designee. Moving forward glucometers will be audited weekly x 8 weeks to ensure correct day and time.

(Directed)
Administrator and/or designee will provide education to staff on how to set glucometer's and how to check them for correct date and time. Education will begin on 8/25/2023. Education to be completed by 9/8/2023. A whole house audit will be completed by 9/11/23 to ensure glucometers are calibrated and set to the appropriate date/time. The day of inspection all glucometers were correctly calibrated to the day and time by the Administrator/designee. Beginning 9/18/23, all glucometers will be audited by the Administrator and/or designee weekly x 8 weeks to ensure correct day and time, any glucometers found to not be calibrated correctly will be corrected immediately by the person conducting the audit.

Directed Completion Date: *09/18/2023*

Not Implemented - 12/04/2023)

187a Medication record

14. Requirements

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

- Resident 6 is prescribed baclofen, cholecalciferol, metoprolol succinate, and a multivitamin, however, these medications do not include a diagnosis or purpose.
- Resident 8 is prescribed amlodipine, chewable aspirin, atorvastatin, donepezil, tamsulosin, trazodone, and vitamin B-12, however, these medications do not include a diagnosis or purpose.

Plan of Correction ***Directed ([redacted] - 08/24/2023)***

Administrator and/or designee completed an audit on 8/10/2023 of all resident's medication records to establish that all residents have diagnoses listed along with their medications. Administrator and/or designee when verifying orders made sure that the diagnosis was added to the order if not already there. Education to be provided to staff on proper way to input order to include the diagnosis. Education to start on 8/25/2023 and be completed no later than 9/8/2023. Daily monitoring of all MAR's to ensure that all diagnosis are entered.

(Directed)
Administrator and/or designee completed an audit on 8/10/2023 of all resident's medication records to establish that all residents have diagnoses listed along with their medications. Administrator and/or designee when verifying orders made sure that the diagnosis was added to the order if not already there. Education to be provided to staff on proper way to input order to include the diagnosis. Education to start on 8/25/2023 and be completed no later than 9/8/2023. Daily monitoring of all MAR's will be completed by the Administrator beginning on 9/11/23, to ensure that all diagnosis are entered. Any missing diagnosis identified in the MAR reviews will immediately be added by the Administrator.

Directed Completion Date: *09/11/2023*

Not Implemented [redacted] - 12/04/2023)

187d Follow prescriber's orders

15. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 2 did not receive the following prescribed medications:
- Cyanocobalamin, 1000 MCGs / ML, inject 1 ML once every 2 weeks, not given on 7/2/23.
- Mirtazapine, 15 MG, 2 tablets at bedtime, not given from 7/1/23 through 7/5.
- Pantoprazole, 20 MG, 1 tablet every day, not given on 7/1/23, 7/3, or 7/7.

Resident 6 did not receive the following prescribed medications:
- Doxycycline Hyclate, 100 MG, 1 capsule twice a day, not given 7/11/23 at 0600 to 1000.
- Furosemide, 20 MG, 1 tablet every day not given 7/2/23 at 0900.
- Gabapentin, 300 MG, 1 capsule twice a day not given on 7/2/23 at 0800

187d Follow prescriber's orders (continued)

- Magnesium Oxide Tablet, 400 MG, give 0.5 tablet 2 times a day, not given 7/2/23 at 0800.
- Advair Discus 250-50 MCG/ACT, 1 inhalation twice a day, not given on 7/2/23 at 0800 or 7/4/23 at 0800

Resident 10 did not receive prescribed Metoprolol Succinate, 75 MG, one tablet daily, on 7/8/23 or 7/14/23.

Plan of Correction ***Directed (- 08/24/2023)***

Administrator and/or designee have done cart audits on both floors and will continue to do cart audits weekly beginning on 8/28/2023 x 4 weeks to ensure all residents receive medications as prescribed by the prescriber. These medications were not delivered from the pharmacy when the new company took over and medications were delivered. Facility is switching back to previous pharmacy to ensure that medications will be delivered on a timely basis. Medications will be on a cycle fill and will not have to be reordered.

(Directed)
Administrator and/or designee have done cart audits on both floors and will continue to do cart audits weekly beginning on 8/28/2023 x 4 weeks to ensure all residents receive medications as prescribed by the prescriber. The Administrator will be responsible for contacting the pharmacy directly for any medications that are identified during the cart audits that will run out before the next medication cycle fill. These medications were not delivered from the pharmacy when the new company took over and medications were delivered. Facility is switching back to previous pharmacy to ensure that medications will be delivered on a timely basis. Medications will be on a cycle fill and will not have to be reordered.

Directed Completion Date: *09/25/2023*

Implemented (12/04/2023)

16. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 2 is prescribed Magnesium Citrate, 100 MG, 2 tables at bedtime, however, it was not given from 7/1/23 through 7/9/23 because it was not available in the residence.

Resident 10 did not receive the following prescribed medications because they were not available in the residence:
- Docusate Sodium, 50 MG, 1 capsule twice a day, not given on 7/2/23 at 0800 or 1600; on 7/3/23 at 0800 or 1600; on 7/4/23 at 0800.
- Ferrous Sulfate, 325 MG, 1 tablet once a day, not given on 7/4/23.
- Pregabalin 75 MG, 1 capsule three times a day, not given on 7/1/23 at 1400; on 7/3/23 at 1400; or 2000; on 7/4/23 at 0800 or 1400

Plan of Correction ***Directed (- 08/24/2023)***

Administrator and/or designee have done cart audits on both floors and will continue to do cart audits weekly beginning on 8/28/2023 x 4 weeks to ensure all residents receive medications as prescribed by the prescriber. These medications were not delivered from the pharmacy when the new company took over and medications were

187d Follow prescriber's orders (continued)

delivered. Facility is switching back to previous pharmacy to ensure that medications will be delivered on a timely basis. Medications will be on a cycle fill and will not have to be reordered.

(Directed)
Administrator and/or designee have done cart audits on both floors and will continue to do cart audits weekly beginning on 8/28/2023 x4 weeks to ensure all residents receive medications as prescribed by the prescriber. The Administrator will be responsible for contacting the pharmacy directly for any medications that are identified during the cart audits that will run out before the next medication cycle fill. These medications were not delivered from the pharmacy when the new company took over and medications were delivered. Facility is switching back to previous pharmacy to ensure that medications will be delivered on a timely basis. Medications will be on a cycle fill and will not have to be reordered.

Directed Completion Date: *09/25/2023*

Implemented [redacted] - 12/04/2023)

190a Completion of course–meds

17. Requirements

2800.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person D, who has not successfully completed the Department-approved medication administration course, administered medications to residents to include the following: on 7/1/23 - 7/3 at 1600 and on 7/5 - 7/8 at 1600.

Staff person E, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following: on 7/10/23, 7/12, 7/13, 7/15. 7/16, 7/19, and 7/20 at 0800.

Plan of Correction ***Directed [redacted] - 08/24/2023)***

Administrator and/or designee will do a complete audit of all medication techs staff files to be completed by 8/16/2023. After a complete audit is completed of all staff files are completed a log will be kept of when all staff is due for their competency testing. Medication observations to be complete by 8/25/2023 for all MedTechs. Both staff person D and E have passed the administration course and both were observed in May of 2023 as part of their annual practicum. Due to this citation, the Administrator/designee had a trainer observe both med techs again in August to complete their 2023 annual practicum.

(Directed)
Administrator and/or designee will do a complete audit of all medication techs staff files to be completed by 8/16/2023. After a complete audit is completed of all staff files are completed a log will be kept of when all staff is due for their competency testing. Medication observations to be complete by 8/25/2023 for all MedTechs. Both staff person D and E have passed the administration course and both were observed in May of 2023 as part of their annual practicum. Due to this citation, the Administrator/designee had a trainer observe both med techs again in

190a Completion of course–meds (continued)

August to complete their 2023 annual practicum. Beginning 10/2/23 the Administrator will create a tracking system to ensure all staff who are trained to administer medications will remain current with medication administration to include medication observations. MAR reviews, and the annual practicum training.

Directed Completion Date: *10/02/2023*

Implemented [redacted] 12/04/2023)

225a1 Assessment – annually

18. Requirements

2800.
225.a.1. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: Annually.

Description of Violation

Resident 7's most recent assessment was completed on [redacted]/21.

Plan of Correction ***Accept ([redacted] - 08/24/2023)***

Administrator and/or designee will do a whole house audit to ensure all residents have a current assessment completed. Whole house audit to be completed by September 10th, 2023. Assessments will be completed quarterly, annually and for change in condition. Administrator or designee will complete a new ASP no later than 8/23/2023.

Licensee's Proposed Overall Completion Date: *09/10/2023*

Not Implemented [redacted] - 12/04/2023)

227d Support plan – med/dental

19. Requirements

2800.
227.d. Each residence shall document in the resident's final support plan the dietary, medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

- The assessment for Resident 1, dated [redacted]/23, does not include information about dietary needs, if any, and how the need will be met.
- The assessment for Resident 2, dated [redacted]/23, does not include information about dietary or dental needs, if any, and how the needs will be met.
- The assessment for Resident 3, dated [redacted]23, does not include information about dietary needs, if any, and how the needs will be met.

Plan of Correction ***Accept ([redacted] - 08/24/2023)***

The administrator and/or designee will do an audit to make sure all resident's support plans to ensure all are

227d Support plan – med/dental (continued)

documented correctly. When it comes to residence dietary needs, medical needs, dental needs, vision and hearing needs as well as their mental health or behavioral health care needs. Audits will be began 8/14/2023 and will be completed by 9/11/2023. Support plans will be updated no later than 8/22/23.

Licensee's Proposed Overall Completion Date: *09/11/2023*

Implemented (12/04/2023)

227g Support plan - signatures

20. Requirements

2800.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The support plans for Residents 1, 2, 3, 4, and 8 are not signed by the assessor.

Plan of Correction ***Accept (- 08/24/2023)***

Moving forward from this date of survey, the administrator and/or designee will create an audit tool as well as implement a QI and QA designee to complete this audit as well as stay compliant with regulations. This is to ensure that all resident support plans are signed by the assessor. Support plans will be signed 8/22/23

Licensee's Proposed Overall Completion Date: *08/22/2023*

Implemented (12/04/2023)

227h Support plan – refusal sign

21. Requirements

2800.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

The support plans for Residents 1, 2, 3, 4, and 8 are not signed by the residents. The residence did not make a notation regarding the refusal or inability of the residents to sign.

Plan of Correction ***Accept (AS - 08/24/2023)***

Moving forward from this date of survey, the administrator and/or designee will create an audit tool as well as implement a QI and QA designee to complete this audit as well as stay compliant with regulations. This is to ensure that all resident support plans are signed by the resident as well as any notations of refusal or inability of the resident to sign. Support plans will be signed 8/22/23

Licensee's Proposed Overall Completion Date: *08/22/2023*

Implemented - 12/04/2023)

252 Records – content

22. Requirements

2800.
252. Content of Resident Records - Each resident's record must include the following information:

252 Records – content *(continued)*

Description of Violation

- Resident 1's record does not include a picture, height, weight, hair color, eye color, and identifying marks, if any.
- Resident 2's record does not include a picture, height, weight, hair color, eye color, religion, and identifying marks, if any.
- Resident 3's record does not include a picture, height, weight, hair color, eye color, and identifying marks, if any.
- Resident 5's record does not include a picture, race, height, weight, hair color, eye color, and identifying marks, if any.
- Resident 7's record does not include a current picture, height, weight, eye color and hair color.
- Resident 8's record does not include a picture, height, weight, eye color, hair color, or identifying marks, if any.

Plan of Correction ***Directed [redacted] - 08/24/2023)***

The administrator did an audit and since the date of survey and corrected the survey findings when it comes to resident records demographics. Administrator or designee updated resident photos the day of inspection. Moving forward demographics will be audited weekly x 3 weeks to ensure all residents have information in the system.

(Directed)
The administrator did an audit and since the date of survey and corrected the survey findings when it comes to resident records demographics. Administrator or designee updated resident photos the day of inspection. Beginning 9/18/23 demographics will be audited by the Administrator weekly x 3 weeks to ensure all residents have information in the system, any missing information identified in the audit will be corrected within 24 hours by the Administrator.

Directed Completion Date: *09/18/2023*

Not Implemented [redacted] - 12/04/2023)

254a Records – discharge/active

23. Requirements

2800.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 7/20/23 at 9:30 AM, a large banker's box of discharged resident records, including medication records, was sitting on a desk in the first-floor office. The box was next to an open pass-through to a hallway which permitted anyone walking by to have access to the box and records contained within.

Plan of Correction ***Accept ([redacted] - 08/24/2023)***

The administrator and/or designee established the large banker's box of resident's records. This box of records was immediately removed and is now secured. An established location was created for resident records which is secured by a lock and key with limited access. Education will be provided to staff on how to safely secure resident records. Education will be completed no later than 9/8/2023.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Implemented ([redacted] - 12/04/2023)

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *THE VILLAGES OF HILLTOP HEIGHTS* **License #:** *33866* **License Expiration:** *07/01/2024*

Address: *100 WOODMONT ROAD, JOHNSTON, PA 15905*

County: *CAMBRIA* **Region:** *CENTRAL*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *THE VILLAGES OF HILLTOP HEIGHTS, LLC*

Address: [redacted]

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *C-1*	**Date:** *06/28/1995*	**Issued By:** *Department of Health*
Type: *C-1*	**Date:** *11/08/1989*	**Issued By:** *Department of Health*
Type: *C-2 LP*	**Date:** *11/01/1987*	**Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *78* **Waking Staff:** *59*

Inspection Information

Type: *Partial* **Notice:** *Unannounced* **BHA Docket #:**

Reason: *Incident, Interim* **Exit Conference Date:** *11/14/2023*

Inspection Dates and Department Representative

11/14/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106* **Residents Served:** *66*

Special Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *65*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *12* **Have Physical Disability:** *3*

Inspections / Reviews

11/14/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/15/2023*

12/18/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/29/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/29/2023*

01/09/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *12/29/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

16d Final Incident report

1. Requirements

2800.
16.d. The residence shall submit a final report, on a form prescribed by the Department, to the Department's assisted living residence office immediately following the conclusion of the investigation.

Description of Violation

On 10/11/23, an incident between two residents occurred. The residence submitted an initial incident report on 10/11/23, however, did not submit a final report to the Department.

Plan of Correction ***Accept [redacted] - 12/18/2023)***

Administrator responsible for submitting this reportable incident is no longer employed at the facility. Moving forward the regional VP will educate the interim administrator on the proper reporting practices on 12/18/2023. Additionally, a final report will be submitted on 12/18/2023 regarding the incident cited. Moving forward the administrator and/or designee will review reportable incidents in the facility's QM meetings held the last week of each month. The next QM meeting will take place on 12/27/2023.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Not Implemented [redacted] - 01/05/2024)

42b Abuse/Neglect

2. Requirements

2800.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 10/11/23 at 7:00 AM, Resident 9 struck Resident 10 multiple times with a disinfectant wipes container.

Plan of Correction ***Accept [redacted] 12/18/2023)***

The administrator or designee will hold whole house abuse education beginning 12/18/2023 and will include all direct care staff, licensed staff, and ancillary staff specific to the ALF. All staff will be educated by 12/22/2023. At this time resident 10 has since discharged from the facility into a more appropriate level of care. Moving forward the administrator or designee will interview 5 residents per month to ensure these residents are free from abuse and neglect. These audits will run from 1/1/2024 through 7/1/2024.

Licensee's Proposed Overall Completion Date: *07/01/2024*

54a Direct care staff quals

3. Requirements

2800.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff A, B, and C do not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Direct care staff person D does not have active registry status on the Pennsylvania nurse aide registry and has a high

54a Direct care staff quals (continued)

school diploma issued by a non-US secondary school.

Plan of Correction ***Accept (- 12/18/2023)***

Staff Member's A, B, and C all have high school diplomas on file as of 12/12/2023. Staff member D is obtaining transcripts from educational institution to include in a waiver application. Moving forward the administrator or designee will create a new hire check list to go over with all new hires to ensure all records are present upon hire. A baseline audit will take place starting on 12/18/2023 and be completed no later than 12/29/2023 of all employee files. To ensure compliance.

Licensee's Proposed Overall Completion Date: *12/29/2023*

Not Implemented (- 01/05/2024)

63a First Aid/CPR 1:35

4. Requirements

2800.
63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

Description of Violation

On the following days and times, there were more than 35 but fewer than 70 residents present in the residence and only 1 staff person working with current training in first aid and certified in obstructed airway techniques and CPR.

10/23/23 from 11:00 PM until 6:30 AM
10/24/23 from 4:30 PM until 6:30 AM
10/25/23 from 4:30 PM until 6:30 AM
10/26/23 from 4:30 PM until 6:30 AM
10/27/23 from 4:30 PM until 6:30 AM

Plan of Correction ***Accept (- 12/18/2023)***

CPR classes are going to be take place on Thursday 12/21/2023 throughout the day to recertify staff. The administrator or designee will complete a baseline audit no later than 12/29/2023 to ensure all necessary staff are CPR certified. Moving forward the administrator or designee will audit employee CPR certifications monthly x 3 months to ensure compliance and will create a binder for all CPR certifications to be easily reviewed.

Licensee's Proposed Overall Completion Date: *12/21/2023*

Not Implemented - 01/05/2024)

65a Fire Safety-1st day

5. Requirements

2800.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

- Staff person A, hired 10/25/23, did not receive orientation on the topics listed in this regulation.
- Staff person B, hired 10/23/23, did not receive orientation on the topics listed in this regulation.
- Staff person C, hired 10/16/23, did not receive orientation on the topics listed in this regulation.

65a Fire Safety-1st day *(continued)*

Plan of Correction ***Accept [redacted] - 12/18/2023)***

Effective immediately, the facility will adopt a new hire orientation checklist to be completed by the administrator or designee. This checklist includes requirements of 65a and 65e. All staff hired between 7/1/2023 and current, will have files audited no later than 12/29/23 to ensure this new hire orientation checklist is complete. Staff without the required trainings will be re-educated no later than 1/5/2023.

Licensee's Proposed Overall Completion Date: *01/05/2024*

Not Implemented [redacted] - 01/05/2024)

65e Rights/Abuse 40 Hours

6. Requirements

2800.
65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

- Staff person A, hired [redacted] 23, did not receive orientation on the topics listed in this regulation.
- Staff person B, hired [redacted] /23, did not receive orientation on the topics listed in this regulation.
-Staff person C, hired [redacted] 23, did not receive orientation on the topics listed in this regulation.

Plan of Correction ***Accept [redacted] - 12/18/2023)***

Effective immediately, the facility will adopt a new hire orientation checklist to be completed by the administrator or designee. This checklist includes requirements of 65a and 65e. All staff hired between 7/1/2023 and current, will have files audited no later than 12/29/23 to ensure this new hire orientation checklist is complete. Staff without the required trainings will be re-educated no later than 1/5/2023.

Licensee's Proposed Overall Completion Date: *01/05/2024*

Not Implemented ([redacted] - 01/05/2024)

87 Lighting

7. Requirements

2800.
87. Lighting - The residence's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

The hallway light in front of bedroom 201 was not functioning.

Plan of Correction ***Accept ([redacted] - 12/18/2023)***

As of 12/11/2023 the light has been replaced and is operational. Moving forward the administrator or designee will educate maintenance staff on 2800.87 by 12/18/2023, and will educate staff on the proper notification of maintenance staff when something is broken or missing by 12/22/2023. The Administrator and/or designee will complete a baseline audit/walkthrough of all resident rooms and hallways no later than 12/31/2023. After the baseline audit is completed, monthly audits of 5 resident rooms and hallways will begin the week of 1/1/2024 and last 6 months.

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] 01/05/2024)

87 Lighting *(continued)*

88a Floors, walls, ceilings, windows, doors

8. Requirements

2800.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

- Bedroom 232 was unoccupied but unlocked and accessible. The light fixture above the bathroom sink was missing and bare electric wires dangled from the wall.
- The light fixture over the bathroom sink in bedroom 205 was not secured to the wall and was dangling from the electric wires.
- There are 4 stained ceiling tiles with brown marks in front of the nurses' station between bedrooms 105 and 106. There are stained ceiling tiles that appear to have been painted over between bedrooms 109 and 110.

Plan of Correction ***Accept [redacted] - 12/18/2023)***

As of 12/11/2023 the only repair left to be made are replacing the ceiling tiles. These tiles will be replaced no later than 1/5/2023 to allow for order if needed. Moving forward the administrator or designee will educate maintenance staff on 2800.88a by 12/18/2023, and will educate staff on the proper notification of maintenance staff when something is broken or missing by 12/22/2023. The Administrator and/or designee will complete a baseline audit/walkthrough of all resident rooms and hallways no later than 12/31/2023. After the baseline audit is completed, monthly audits of 5 resident rooms and hallways will begin the week of 1/1/2024 and last 6 months.

Licensee's Proposed Overall Completion Date: *12/31/2023*

Not Implemented [redacted] - 01/05/2024)

101n Walls, floors & ceilings

9. Requirements

2800.
101.n. The living unit must have walls, floors and ceilings, which are finished, clean and in good repair.

Description of Violation

There is a hole in the drywall behind the door in bedroom 210 where the doorstop is missing.

Plan of Correction ***Accept ([redacted] - 12/18/2023)***

As of 12/11/2023 the wall has since been repaired. Moving forward the administrator or designee will educate maintenance staff on 2800.101 by 12/18/2023, and will educate staff on the proper notification of maintenance staff when something is broken or missing by 12/22/2023. The Administrator and/or designee will complete a baseline audit/walkthrough of all resident rooms and hallways no later than 12/31/2023. After the baseline audit is completed, monthly audits of 5 resident rooms and hallways will begin the week of 1/1/2024 and last 6 months..

Licensee's Proposed Overall Completion Date: *12/31/2023*

Not Implemented ([redacted] - 01/05/2024)

141a Medical evaluation

10. Requirements

141a Medical evaluation *(continued)*

2800.
141.a.2 A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following: (11)

Description of Violation

The medical evaluation for Resident 1, dated [redacted]/23, does not include an indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. This area of the form is blank.

Plan of Correction ***Accept[redacted] - 12/18/2023)***

Resident #1 received PPD skin test on [redacted]/23 and added to the ADME by the administrator by 12/22/23. The administrator or designee will conduct a baseline audit of all resident ADMEs no later than 1/5/2023 to ensure each ADME has the initial PPD skin test within two years of admission documented. ADME dates will be added to the facility's ASP spreadsheet in order to track annual ADME dates.

Licensee's Proposed Overall Completion Date: *01/05/2024*

Not Implemented[redacted] - 01/05/2024)

183b Medications and syringes locked

11. Requirements

2800.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's living unit.

Description of Violation

On 11/14/23 at 9:45 AM, two aerosol cans of anti-fungal spray and a bottle of CVS-brand anti-fungal powder were unlocked, unattended, and accessible in Resident 2 and 3's bathroom.

Repeated Violation - 5/5/23, et al.

Plan of Correction ***Accept[redacted] 12/18/2023)***

The day of inspection these items were removed from the resident's bathroom and locked in the appropriate containers. Staff will be educated on 2800.183b and the proper procedures to keep medications locked in appropriate places no later than 12/22/23. A baseline audit of all resident bathrooms will take place and be completed by 1/5/2023, conducted by the administrator or designee. Moving forward, 10 resident rooms will be audited, by the administrator or designee, per week x 3 weeks and monthly thereafter to ensure compliance with this regulation. These audits will begin the week of 1/8/24.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Implemented[redacted] 01/05/2024)

185a Storage procedures

12. Requirements

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident glucometers were not programed with the correct times. The meters included:

185a Storage procedures (continued)

- Resident 4's meter which stated 4:27 PM at 3:27 PM
- Resident 5's meter which stated 4:43 PM at 3:43 PM
- Resident 6's meter which stated 1450 at 3:50 PM
- Resident 7's meter which stated 5:03 PM at 4:05 PM
- Resident 8's meter which stated 5:12 PM at 4:12 PM

Plan of Correction ***Accept ([redacted] - 12/18/2023)***

By 12/18/2023 the administrator or designee will conduct a baseline audit of all glucometers in the facility. Glucometers will have time and date corrected where needed. Moving forward the facility will begin monthly glucometer audits conducted by the administrator or designee to ensure compliance. These audits will begin the week of 1/1/24 and will be kept in a binder specific to glucometer audits.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Not Implemented [redacted] - 01/05/2024)

187a Medication record

13. Requirements

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident 7 is prescribed Humalog KwikPen Insulin, however, the medication record from 11/2/23 - onward does not include the diagnosis or purpose for this medication.

Resident 3 is prescribed Acetaminophen tablets, 500 mg, 3 times a day, however, the medication record does not include the diagnosis or purpose for this medication.

Plan of Correction ***Accept [redacted] 12/18/2023)***

By 12/18/2023 the administrator or designee will ensure resident #3 and #7 has diagnoses attached to each of their medication orders. The administrator or designee will conduct a baseline audit no later than 12/31/2023 to ensure each resident has a diagnosis associated with ordered medication. All residents will have diagnoses added no later than 12/18/23. Administrator or designee will conduct education for staff responsible for order entry no later than 12/18/23 on 2800.187a; documentation of the training will be kept in accordance with 2800.65l. Moving forward Administrator or designee will audit 5 random resident EMARs weekly x 3 weeks, then monthly x3 months to ensure compliance is maintained.

Licensee's Proposed Overall Completion Date: *12/18/2023*

Not Implemented [redacted] - 01/05/2024)

225a1 Assessment – annually

14. Requirements

2800.

225a1 Assessment – annually *(continued)*

225.a.1. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: Annually.

Description of Violation

Resident 5's most recent assessment was completed on [redacted]/21.
Resident 4's most recent assessment was completed on [redacted]/21.

Plan of Correction ***Accept [redacted] - 12/18/2023)***

Staff responsible for ASP will be reeducated on the ASP requirements, as well as the home's procedures for updating resident ASP's as resident care needs change no later than 12/18/2023 by the regional VP. Resident 4 and 5 will have new assessments completed no later than 12/20/2023. Moving forward a whole house audit and update of resident ASPs will be completed no later than 1/12/2024. Documentation of the training will be kept in accordance with 2800.65l. Updates will be made to ASPs where needed and these updates will be completed. Starting 1/1/2024, the administrator shall review 5 resident assessments monthly to ensure accuracy and to ensure compliance with this violation. While audits are being completed, the administrator or designee will create a spreadsheet to monitor dates of ADME/ASP in order to remain in compliance moving forward. The spreadsheet shall be created by the administrator or designee by 12/31/23, and reviewed monthly beginning 1/1/2024

Licensee's Proposed Overall Completion Date: *12/31/2023*

Not Implemented [redacted] 01/05/2024)

225a2 Assessment – significant change

15. Requirements

2800.
225.a.2. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

On 10/11/23, Resident 9 struck another resident with a disinfectant wipes container. Resident 9's assessment, dated [redacted]/23, does not include this aggressive behavior or how the home will address it. An additional written assessment was not completed.

Plan of Correction ***Accept [redacted] - 12/18/2023)***

Staff responsible for ASP will be reeducated on the ASP requirements, as well as the home's procedures for updating resident ASP's as resident care needs change no later than 12/18/2023 by the regional VP. Resident 9 will have an updated assessment completed no later than 12/20/2023. Moving forward a whole house audit and update of resident ASPs will be completed no later than 1/12/2024. Documentation of the training will be kept in accordance with 2800.65l. Updates will be made to ASPs where needed and these updates will be completed. Starting 1/12/2024, the administrator shall review 5 resident assessments monthly to ensure accuracy and to ensure compliance with this violation. While audits are being completed, the administrator or designee will create a spreadsheet to monitor dates of ADME/ASP in order to remain in compliance moving forward. The spreadsheet shall be created by the administrator or designee by 12/31/23, and reviewed monthly beginning 1/1/2024

Licensee's Proposed Overall Completion Date: *12/31/2023*

225a2 Assessment – significant change *(continued)*

Not Implemented (01/05/2024)

252 Records – content

16. Requirements

2800.
252. Content of Resident Records - Each resident's record must include the following information:

Description of Violation

The records for Residents 1, 4, 5, 8, 9, and 10 do not include hair color, eye color and any identifying marks.

Plan of Correction ***Accept 12/18/2023)***

No later than 12/22/23 the administrator or designee will add this information into resident 1, 4, 5, 8, and 9's face sheet notes. Education will be provided for 2800.252 to staff responsible for admission and demographic entry by 12/18/2023. Moving forward, the administrator or designee will complete a baseline audit and ensure all residents have this information in their face sheet no later than 1/12/2024.

Licensee's Proposed Overall Completion Date: *12/22/2023*

Not Implemented - 01/05/2024)